



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Trofile Assay and Selzentry (maraviroc) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

**PA is required for all Selzentry (maraviroc) and Trofile Assay requests.**

Information about the MassHealth Drug List can be found at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

<input type="checkbox"/> trofile assay	<input type="checkbox"/> Selzentry (maraviroc) (evidence of a positive assay is required for approval)
Dose, frequency, and duration	

#### Indication

☐ HIV-1 ☐ Other (specify): \_\_\_\_\_  
Current viral load \_\_\_\_\_

#### Section I

1. Does your patient have treatment failure documented by an HIV-1 RNA > 5,000 copies/ml despite at least 6 months of prior therapy with at least one agent from three of the four antiretroviral categories listed below?

- ☐ ≥1 nucleoside reverse transcriptase inhibitors (NRTI)
- ☐ ≥1 non-nucleoside reverse transcriptase inhibitors (NNRTI)
- ☐ ≥2 protease inhibitors (PI)
- ☐ enfuvirtide (fusion inhibitor)

☐ yes ☐ if no, - Please provide documentation of medical necessity or rationale for requested assay or medication.

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## Section II

### Treatment Plan

1. If requesting maraviroc, please provide results of trofile assay indicating positive CCR5-tropic HIV-1 infection.

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2. If requesting maraviroc, will concurrent antiretroviral therapy be prescribed?

- ☐ Yes. Please provide treatment regimen below.
- ☐ No. Please provide rationale why combination therapy is not indicated below.

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## Pharmacy information

Name	Pharmacy provider no. <i>Optional</i>	Telephone no. (     )	Fax no. (     ) <i>Optional</i>
Address	City	State	Zip <i>Optional</i>

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address <i>Optional</i>			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date